REPORT BY THE

AUDITOR GENERAL

OF CALIFORNIA

REVIEW OF THE BOARD OF MEDICAL QUALITY ASSURANCE

P-035

AUGUST 1982

REPORT BY THE

OFFICE OF THE AUDITOR GENERAL

TO THE

JOINT LEGISLATIVE AUDIT COMMITTEE

035

REVIEW OF THE BOARD OF MEDICAL QUALITY ASSURANCE

AUGUST 1982

California Legislature

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August 13, 1982 P-035

The Honorable President pro Tempore of the Senate
The Honorable Speaker of the Assembly
The Honorable Members of the Senate and the
Assembly of the Legislature of California

Members of the Legislature:

Transmitted herewith is the Auditor General's report on the Board of Medical Quality Assurance (BMQA). The BMQA is divided into three autonomous divisions; Allied Health, Licensing, and Medical Quality. The purpose of the BMQA and its three divisions is to protect the consumer from incompetent, grossly negligent, unlicensed, or unethical practitioners. The Board further serves to educate the public and the medical practitioner on health quality issues.

The Division of Medical Quality is responsible for disciplining physicians who are found to be in violation of the Medical Practice Act. The Auditor General's review specifically examined the complaint, investigation, and disciplinary procedures employed by the BMQA against physicians alleged to have violated legal or ethical standards.

The Auditor General's audit revealed that the Board acted appropriately in most of its investigations that the auditors reviewed. Some instances, however, were found which demonstrated areas where procedures could be improved. Specifically, improvements are needed in enforcement procedures for interviewing physicians, conducting arrests and requiring physicians to submit to psychiatric examinations.

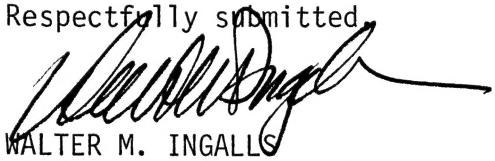
Review of the Diversion Program for impaired physicians disclosed deficiencies in monitoring and enforcing treatment programs. Also, Diversion Program participants who do not comply with their treatment programs are not being referred back to the enforcement program for possible disciplinary action.

These deficiencies are the result of a program which lacks established policies and procedures to monitor compliance with treatment programs. As a result, there are no assurances that the public will be protected through the process of rehabilitating physicians who suffer from drug or alcohol abuse, or from physical or mental illness.

The Auditor General recommends that the Diversion Program develop a more structured job description and performance measures for compliance officers to use in enforcing the Diversion Program. The Board has responded that it has limited statutory authority in disciplining physicians who do not practice their healing arts in a professional, legal or ethical manner.

The Board is encouraged to bring their recommendations to the Legislature, keeping in mind that any proposals should consider protecting the rights of physicians, and furthering public protection.

Respectfully submitted,



WALTER M. INGALLS
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SUMMARY

The Board of Medical Quality Assurance (board) is responsible for reviewing the quality of medical practice carried out by physicians and surgeons. Although the board acted appropriately in most of the investigations we reviewed, the board could improve its enforcement procedures for interviewing physicians, conducting arrests, and requiring physicians to submit to psychiatric examinations. The board should also continue its efforts to employ a nondisciplinary approach to the inappropriate prescribing practices of some physicians. Also, because of limitations in its statutory authority, the board is restricted in the actions it can take against physicians who demonstrate negligence in their medical practices.

Our review of the Diversion Program for Impaired Physicians disclosed two deficiencies. First, compliance officers are not adequately monitoring and enforcing treatment programs. Second, participants diverted from the enforcement process who do not comply with their treatment programs are not being terminated from the program and referred back to the enforcement program for possible disciplinary action. These deficiencies result from a lack of established policies and procedures for monitoring compliance with treatment programs

and from a lack of standards for terminating participants. As a result, there is no assurance that the public is being adequately protected during the process of rehabilitating physicians who suffer from drug or alcohol abuse or from physical or mental illness.

To correct the problems with its enforcement procedures, the board should interview physicians charged with noncriminal violations, evaluate whether to employ alternatives to physical arrest, inform physicians of their right to submit evidence in their behalf when they are required to have a psychiatric examination, and place a high priority on educating physicians in appropriate drug prescribing practices. The board should also recommend to the Legislature methods of dealing more effectively with physicians who demonstrate simple negligence in their medical practices.

During our review of the Diversion Program for Impaired Physicians, the board initiated action to correct deficiencies we identified in monitoring and enforcing the treatment plans and in terminating participants from the program. The board plans to hire additional staff, has drafted guidelines for enforcing some provisions of the treatment plans, and has established general standards for terminating participants. In addition, the board should establish a

schedule for completing the other tasks necessary for correcting these deficiencies. Specifically, the board needs to establish guidelines for the frequency with which compliance officers should contact participants, to develop a more structured job description and performance measures for compliance officers, and to specify criteria for terminating participants from the program.

This report also provides information requested by the Legislature on physicians required to work in supervised, structured environments employed in state hospitals and on examples of conduct by physicians and surgeons that warranted denial of their applications for licensing.

INTRODUCTION

In response to audit requests from the Joint Legislative Audit Committee, we have reviewed the activities of the Board of Medical Quality Assurance. This audit was conducted under the authority vested in the Auditor General by Sections 10527 through 10528 of the Government Code.

BACKGROUND

The Board of Medical Quality Assurance (board) is an administrative agency within the State Department of Consumer Affairs. The board, which consists of 19 members appointed by the Governor, is divided into 3 autonomous divisions. The Division of Medical Quality is responsible for reviewing the quality of medical practice carried out by physicians and surgeons; this responsibility includes enforcing the disciplinary and criminal provisions of the Medical Practice Act. The responsibilities of the Division of Licensing include issuing licenses and certificates under the board's jurisdiction and administering the board's continuing medical education program. The Division of Allied Health Professions oversees licentiates, such as psychologists, podiatrists, and acupuncturists. The responsibilities of the division include

administering and hearing disciplinary actions against licentiates except for physicians and surgeons, to the extent that such actions are directly within the board's jurisdiction.

The board's activities are funded primarily by licensing fees collected from physicians and surgeons; it does not receive any money from the State's General Fund. The board's total net expenditures for fiscal year 1981-82 are estimated to be $10.2 million. Its proposed expenditures for fiscal year 1982-83 are $10.9 million.

Table 1 on the next page illustrates the extent of enforcement activities taken against physicians and surgeons from 1979 through 1981. To provide perspective on the number of physicians actually affected by the board's enforcement activity, we have included the number of licensed physicians each year as well as the number of complaints received and the number of investigations conducted. The number of cases closed with merit reflect those cases in which the board identified deficiencies in physicians' medical practices but could not document violations of the Medical Practice Act. The number of accusations filed represents those cases in which the board has alleged that physicians have violated provisions of the Medical

Practice Act and has filed charges against physicians. The number of disciplinary actions reflects the cases in which physicians were found guilty of violating the Medical Practice Act.

TABLE 1

NUMBER OF LICENSED PHYSICIANS AND SURGEONS
AND EXTENT OF ENFORCEMENT ACTIVITY AGAINST THEM
1979 THROUGH 1981[a]

	1979	1980	1981
Licensed Physicians and Surgeons[b]	52,850	55,131	57,290
Complaints Received	3,802	3,492	3,071
Investigations Conducted	1,634	1,767	1,646
Cases Closed With Merit	1,077	1,072	1,285
Accusations Filed	186	138	180
Disciplinary Actions	113	139	123

[a] The number of accusations filed and disciplinary actions taken in any year do not necessarily result from complaints received that year because many cases are carried over from previous years.

[b] These figures reflect only those licensees whose address of record is in California.

SCOPE AND METHODOLOGY

In addition to audit requests that required us to review the board's enforcement activity, we also received complaints from physicians who had been investigated by the

board. They presented us with a variety of complaints, which we investigated, about alleged improprieties and abuse of authority by the board's enforcement staff. We reviewed the board's statutory authority to conduct investigations and its policies and procedures. We also reviewed case files of physicians from whom we received complaints, and we interviewed the investigators and supervisors involved in those cases. To assist us in our evaluation, we also discussed the board's investigative procedures with law enforcement professionals, including the Commission on Peace Officer Standards and Training, the Peace Officers Research Association of California, and district attorneys.

We were also contacted by consumers and another physician who had filed complaints with the board against physicians. These people felt that the board was ineffective in handling their complaints. To evaluate the board's effectiveness in these cases, we reviewed the case files of the physicians who were the subjects of the complaints.

We were also asked to review the Diversion Program for Impaired Physicians. We analyzed a sample of case files to determine how well physicians are being monitored during their participation in the program. To review program operations and to obtain information on the status of proposed improvements in the program, we interviewed members of the board's management.

To respond to a request about the status of physicians required to work in supervised, structured environments who are employed in state hospitals, we first reviewed their case files to determine the nature of their violations of the Medical Practice Act and the extent of supervision required by the board. We then determined their responsibilities for providing medical care at state hospitals and verified the extent of their supervision by contacting the administrators of the state hospitals involved.

In response to another request, we compiled examples of conduct by physicians that warranted denial of their applications for licensing. We obtained these examples by reviewing the files of all physicians denied licenses since 1976. We also determined what procedures the Division of Licensing uses in processing applications.

Finally, we tested the board's compliance with specific statutory and procedural requirements. In three of the board's four regional offices, we reviewed a sample of complaints processed by the consumer services representatives for timeliness and appropriateness of actions taken. We also examined a sample of cases in which no violations were detected to determine if those case files were being purged from the Sacramento headquarters' and the regional offices' files in accordance with board policy. We also reviewed the probation

surveillance monitoring system in three of the four regional offices. We examined a sample of cases to determine if the probation surveillance officers were monitoring all the terms and conditions of probation and to see how violations of probation are handled.

AUDIT RESULTS

I

SOME OF THE ENFORCEMENT PROCEDURES OF THE BOARD OF MEDICAL QUALITY ASSURANCE COULD BE IMPROVED

The Enforcement Program of the Division of Medical Quality is responsible for taking action against all persons guilty of violating the Medical Practice Act. We found that the board acted appropriately in most of the investigations we reviewed. However, we found instances in which the board could improve its enforcement procedures for interviewing physicians, conducting arrests, and requiring physicians to submit to psychiatric examinations. The board should also continue its efforts to place a high priority on educating physicians in appropriate drug-prescribing practices. Finally, because of limitations in its statutory authority, the board is restricted in the actions it can take against physicians who demonstrate deficiencies in competency.

Various physicians who have been investigated by the board and individuals who have filed complaints with the board about physicians have alleged that the board engages in improper enforcement practices. We grouped these complaints about improper enforcement practices into three phases of

the enforcement process: opening cases against physicians, conducting investigations, and taking disciplinary actions. The three phases and the specific complaints are shown below.

Opening Cases Against Physicians

- Inappropriate opening of cases.

Conducting Investigations

- Physicians are not always interviewed during the course of the investigation.
- Entrapment by special operators in cases involving allegations of improper prescribing.
- Inappropriate examination of patient records.
- Noncompliance with the opinion of an outside medical expert.
- Arresting and handcuffing physicians.
- Denial of hearings on orders to require psychiatric examinations.

Taking Disciplinary Actions

- Serving the physician an accusation after it has appeared in the newspaper.
- Overemphasis on disciplinary actions against physicians who excessively prescribe drugs.
- Ineffective handling of cases.

Not all of the complaints we received dealt with the Board of Medical Quality Assurance. One of the complaints actually related to the actions of another agency that is also involved in investigating physicians. (Appendix A describes the roles and responsibilities of other federal and state agencies.)

In the sections that follow, we address each of the specific complaints made against the board and discuss the appropriateness of the board's actions.

Opening Cases Against Physicians

Consumer service representatives receive all complaints against physicians, surgeons, and healing arts professionals licensed by the board. (Appendix B provides information about the various sources of these complaints.) The representative determines whether the complaint is within the board's investigative jurisdiction. Depending upon the allegations in the complaint, a supervising investigator and a medical consultant may also review it. If the board staff determine that a complaint does not involve a violation of the Medical Practice Act, the complaint is either closed or referred to an appropriate agency in the private or public

sector. If staff determine that a violation may exist, the complaint is assigned to a field investigator for investigation.

Inappropriate Opening of Cases

To evaluate the complaint that cases are inappropriately opened, we reviewed the performance of consumer service representatives and found that the board is opening cases appropriately. Cases are opened for investigation if a violation of the Medical Practice Act appears to exist. If complaints are not within the board's jurisdiction, they are referred to other regulatory boards or to medical societies. In some instances, such as those involving medical ethics or fee disputes, the complaint is either mediated informally or dismissed.

Conducting Investigations

Any complaint or report that may involve an alleged violation of the Medical Practice Act is investigated. Upon completing an investigation, the investigator and supervisor evaluate the collected evidence and necessary medical records. When necessary, the case is referred to a regional medical consultant who provides technical assistance and medical interpretation of the accumulated evidence.

In certain cases, regional medical consultants arrange for other medical experts, such as medical school professors or physicians in the specialty involved in the case, to make an independent evaluation of the issues. If necessary, these experts are prepared to support their medical opinions at formal hearings.

Interviewing Physicians Under Investigation

Based on our review of complaints that investigators are not interviewing physicians, we found that the board does not always provide physicians with an opportunity to be interviewed. Interviewing is not a required investigative procedure. However, the board states that its general practice is to contact the physician for an interview some time during the investigation, usually after investigators have obtained all of their evidence.

We reviewed the investigations of the five physicians who complained that they were not interviewed and found that the board acted appropriately in three of these cases. One physican was given the opportunity to be interviewed, but the board investigator who handled the case informed us that the physician's attorney advised against the interview. In the second case, the physician's attorney provided the board's investigator with explanatory material about the physician's

actions. The third case involved criminal charges, and in such instances the board's procedures do not require the physicians to be interviewed. This practice of not interviewing physicians charged with criminal violations was endorsed as standard law enforcement procedure by law enforcement professionals at the Commission on Peace Officer Standards and Training and the Peace Officers Research Association of California.

In two remaining cases, however, we found that the board did not give the physicians an opportunity to be interviewed. In one of the cases, the physician was not interviewed although the investigator attempted to arrange a meeting several times. Ultimately, the board's attorney advised against the interview because he felt it would not be productive. In the other case, the investigator felt that he had obtained sufficient evidence against the physician and did not feel that interviewing the physician was necessary.

We could not determine whether interviewing the physician affects the outcome of an investigation. Physicians' attorneys report that a physician being investigated should have the opportunity to defend his or her actions before being accused of violating the Medical Practice Act. Further, some physicians maintain that if they were interviewed, they could

provide the reasoning for the specific medical treatment in question. If the physician's explanation convinces the board's staff that the physician's action is appropriate, then the time and expense of filing an accusation and going to a hearing would be minimized. Based upon these discussions with physicians and attorneys, we have concluded that in noncriminal cases the physician should be given the opportunity in an interview to explain his or her actions once the investigator has obtained the evidence against the physician.

Entrapment by Special Operators

In our review of complaints that special operators have entrapped physicians, we found that the board's policy does not involve entrapment. Entrapment occurs when, for the purpose of instituting a criminal prosecution against a person, agents of the government induce that person to commit a crime that he or she did not contemplate committing. However, the act of furnishing a person with an opportunity to commit a crime, where intent was already present, is not ordinarily entrapment. The board uses special operators in a case after investigators have obtained substantial evidence that a physician has inappropriately prescribed drugs. Inappropriate prescribing includes cases in which a physician clearly and repeatedly prescribes drugs in excess as well as cases in which

a physician repeatedly prescribes dangerous drugs without first conducting a medical examination and without demonstrating a medical need for the drug prescribed.

Before it employs special operators in a case, the board obtains evidence of a physician's intent to commit a crime. For example, the Bureau of Narcotic Enforcement within the California Department of Justice provides the board with information on physicians' practices of prescribing controlled substances. Also, audits of pharmacy records conducted by agents of the Bureau of Narcotic Enforcement or by the board's investigators may provide evidence of inappropriate prescribing. To substantiate charges of inappropriate prescribing, the board often must demonstrate that the physician did not conduct a medical examination and did not detect a medical need for the drug prescribed. Sometimes the physician's patients are not willing to provide evidence because doing so would cut off their source of drugs. Consequently, special operators are necessary to confirm that a violation has occurred.

Examination of
Patient Records

We evaluated the complaint that the board was obtaining patient records improperly and determined that the board had acted within its statutory authority. State statutes

enable board investigators to examine in the physician's office the records of those patients who have complained about the physician. In addition, investigators may use formal means to seize records from the physician's office or from hospitals. For example, patients may relinquish their medical records to investigators by signing medical record releases. The board may also obtain records with the physician's consent or by using investigative subpoenas and search warrants.

We received two complaints that the board had improperly obtained records. However, in the first case, the board obtained a medical record release from the patient's mother. In the second case, the board obtained the records through patient record releases, investigative subpoenas, and with the physician's consent. Furthermore, our review of other investigation reports showed that the board properly obtained patients' medical records.

Use of Medical Experts

Contrary to the complaint we received, we found that the board does comply with the opinions of outside medical experts. If the medical consultant determines or is uncertain that a violation has occurred, the consultant refers the case to an outside medical expert for review. In general, cases are referred to two outside medical experts for single-incident

cases and to one expert for multiple-incident cases. In single-incident cases, the board uses more than one expert because there is less certainty that a pattern of negligent practice exists. However, members of the board's staff explained that in multiple-incident cases, review by one expert is generally sufficient because there is greater probability that negligent practice exists. The board's policy is generally to close with merit, those single-incident cases in which one expert finds a violation but the second does not. Cases closed with merit include those in which wrongdoing has occurred but in which no clear violation of the Medical Practice Act can be substantiated. In multiple-incident cases, if the outside expert finds no violation, the medical consultant decides either to close the case or to refer it to another expert for review.

We received one complaint that the board ignored an expert opinion exonerating a physician's actions. In our review of the investigative file, we found that three outside experts reviewed the case; the first expert found merit with all three of the allegations, while the second expert found merit with only one of the allegations. A third expert was contacted to review the case and found merit with all three of the allegations. The board subsequently filed an accusation against the physician and included all three of the

allegations. We also reviewed a sample of other cases in which medical experts were used and found that the board is consistently following its policies and procedures.

Arrest and Handcuffing

We evaluated complaints of inappropriate arrest and handcuffing of physicians and found that the board appears to be complying with standard arrest and handcuffing procedures. However, alternatives to physical arrest are available and are being used by another agency that arrests physicians. Consequently, the board should evaluate its policy of relying exclusively on physical arrest.

The California Penal Code designates board investigators as peace officers who have the authority to arrest violators of criminal law (e.g., narcotics laws). In addition, according to the board's policies and procedures for arresting and handcuffing physicians, the board's investigators generally obtain arrest warrants before making arrests even though they are not required to do so. To obtain an arrest warrant, board investigators first refer the case to a district attorney's office. After reviewing the case, a deputy district attorney files the warrant for the board by drafting a formal

complaint report and presenting it to a judge. The judge reviews the warrant and signs it if the complaint constitutes a criminal violation.

We found that the board conducts arrests properly. All the cases in which physicians charged inappropriate arrest involved criminal violations, and in each case the investigators obtained arrest warrants before making the arrests. These physicians also complained that they were treated abusively by investigators during the arrest and that as a result, their medical careers were irreparably damaged. We were unable to confirm exactly what transpired during these arrests, but we did determine that the board's policy specifies that the investigators are to handcuff physicians outside of their offices so as not to embarrass the physicians in front of their patients. If the physicians become hostile or resist arrest, however, they will be handcuffed immediately.

We also reviewed the appropriateness of using handcuffs in arrests by discussing the matter with the members of the Commission on Peace Officer Standards and Training and the Peace Officers Research Association of California. They reported that handcuffing is standard procedure in conducting arrests, and that the purpose of handcuffing is to ensure the

safety of the arresting officer and the subject. In addition, some local jails will not accept a person for booking unless the person is handcuffed when brought in.

During our review, we identified alternatives to physical arrest. For example, voluntary surrender by the physician is an option available to the arresting agency in misdemeanor or felony cases. After obtaining an arrest warrant, the arresting agency notifies the physician or the physician's attorney of the arrest warrant and asks the physician to surrender voluntarily for booking at the jail site. There are, however, risks involved. The physician may flee upon notification of a warrant for arrest, or the physician may alter or destroy medical records that would otherwise be used as evidence.

The Department of Justice Medi-Cal Fraud Unit frequently uses voluntary surrender in cases dealing solely with fraud. The Medi-Cal Fraud Unit permits a physician to surrender voluntarily when two criteria are met. First, the investigator must deem that the subject is not dangerous (not likely to use a weapon). Second, the investigator must also determine that the physician has sufficient community ties, such as owning property in the community and having a family, to ensure that he or she will not leave town.

Another alternative to physical arrest is the issuance of citations for misdemeanor violations. Under this option, the subject is notified to appear in court for arraignment but is not officially booked. The court has discretion over booking the subject after the arraignment. According to a district attorney, there is a problem involved here as well. If the judge dispenses with booking the physician, no record of previous arrest will exist should the subject ever be arrested again.

Hearings on Orders to Require Psychiatric Examinations

The board has developed a procedure concerning orders to require psychiatric examinations. According to this procedure, a physician is allowed to present evidence supporting his or her mental fitness before submitting to a psychiatric examination. However, the board has not yet made this procedure widely known. Physicians should be informed, when sent the orders, of their right to provide the Division of Medical Quality with evidence of their mental fitness before they submit to the psychiatric examinations.

To evaluate the complaints that the board has denied physicians hearings on orders to require psychiatric examinations, we reviewed the board's policy and procedures for

ordering psychiatric examinations. First, a deputy attorney general drafts a petition and an "Order Compelling Psychiatric Examination." Board staff then submit the petition and the order to the Division of Medical Quality for approval. If the division approves the petition and the order, the physician is required to submit to a psychiatric examination. Upon being notified of the order, the physician may present to the division evidence supporting his or her mental fitness.

With a deputy attorney general, we reviewed the status of a physician's right to a hearing to contest the order requiring a psychiatric examination. We also reviewed a Superior Court ruling in a suit filed by a physician because the board had ordered him to submit to a psychiatric examination without first conducting a hearing. We found that physicians have no legal right to a hearing on an "Order Compelling Psychiatric Examination" because a psychiatric examination is part of the investigative, not the disciplinary, phase of a case. In addition, complying with the order has no effect on the physician's license unless a psychiatrist finds the physician mentally ill to the extent that his or her ability to practice medicine safely is impaired, in which case the board would have to initiate disciplinary action. Lastly, hearings are not granted because alleged mental illness must be acted upon immediately for public safety, and a hearing would slow down the process.

Taking Disciplinary Actions

When the investigative process has been completed, the board refers those cases involving criminal violations to a district attorney's office for possible prosecution. Cases that do not involve criminal violations or that have been prosecuted by the district attorney and still have merit regarding administrative violations are referred to the Office of the Attorney General for possible disciplinary action against the subjects' licenses.

After reviewing the case, the deputy attorney general decides whether to file an accusation against the subject. If an accusation is prepared, the deputy attorney general also schedules a hearing. Not all accusations result in a hearing, however. Some are settled by a stipulated agreement reached between the physician and the Attorney General. Stipulated agreements are subject to approval by the Division of Medical Quality.

Cases that do require administrative hearings are heard before an Administrative Law Judge or a regional Medical Quality Review Committee. The decision proposed by the Administrative Law Judge is subject to review by the Division of Medical Quality, which has the authority to approve, reject,

or alter the proposed decision. Most proposed decisions rendered by a Medical Quality Review Committee are also subject to approval by the Division of Medical Quality.

A physician dissatisfied with the final decision reached by the Division of Medical Quality has the right to petition the division for reconsideration or to petition the court system to review the case for legal errors. This process of judicial review includes the right to petition the Superior Court to review the division's actions and to petition for appeal to the Court of Appeal and to the Supreme Court.

Serving Accusations

In the past, procedural delays have resulted in some physicians' seeing their accusations mentioned in the newspaper before they were officially served with those accusations. However, according to the new policy implemented in January 1982, the board now serves all accusations on physicians and refrains from public comment for 10 days. This procedure minimizes the chances that the general public will hear of an accusation before the physician does.

Under the board's former procedure, the executive director signed the accusation upon receiving it from a deputy attorney general. The board's legal staff then prepared the

official record of the accusation (called "filing"). Upon filing, the accusation became a public record. The accusation was then mailed back to the deputy attorney general, who served it on the physician by mail or in person. Because of the delay inherent in this procedure, reporters who had learned about the accusation obtained it from the board and made it public before the physician received it.

Actions Against Physicians Who Excessively Prescribe Drugs

In 1981 the largest proportion of disciplinary actions, 26 percent, involved excessive prescribing or treatment. At the April 1982 board meeting, however, the Division of Medical Quality decided to develop systems to identify physician's prescribing behavior and to modify this behavior through nondisciplinary means.

The board has also developed a policy to deal both with physicians who prescribe excessively and with physicians who prescribe drugs without performing a medical examination and without detecting a medical need for the drug prescribed. According to the new policy, those physicians whose prescribing practices do not harm patients will be handled by nondisciplinary review. These physicians must, however, be well-intentioned in their prescribing: they must be motivated

by an intent to help their patients, not by an intent solely to make money. Physicians volunteer to participate in nondisciplinary reviews, which result in recommendations to the physician on how his or her medical practice can be improved. Six months after the nondisciplinary review, the medical consultant reviews with the physician whether the recommendations have been implemented.

The board has also developed a project to review the prescribing practices of physicians. The board began the project in the Monterey area to identify physicians who excessively prescribe. First, investigators audited pharmacy records to determine the prescribing practices of physicians. Sixteen physicians in the community were identified as excessively prescribing drugs. In June 1981, the board held a nondisciplinary educational conference at the local medical society for the physicians who were identified. The conference included discussion of appropriate prescribing levels of controlled substances. Six months later, the board followed up on the 16 physicians and found that only 1 appeared to be still prescribing excessively.

The board is conducting a similar project in Santa Rosa, and the completed pharmacy audits have identified between 7 and 10 physicians who may be prescribing excessively. Currently, the board is preparing educational meetings for the

Santa Rosa area similar to those held in Monterey. The board has also proposed conducting the project in two locations in Southern California and one more location in Northern California.

Finally, a joint statement issued by the board and the California Medical Association on the prescribing of some nonnarcotic controlled substances was sent to all California physicians in 1981. This statement was also appended to an article appearing in the March 1982 edition of The Western Journal of Medicine--California Section. The article, written by the board's San Mateo regional medical consultant, provided information on the medical and legal standards for prescribing dangerous drugs.

Handling of Cases

We evaluated the charge that the board is not effectively handling all of its cases and found that limitations to its statutory authority often restrict the actions that the board can take against physicians who have demonstrated deficiencies in competency.

Although the board receives many complaints that demonstrate deficiencies in physicians' practices, many of these complaints involve deficiencies that are not severe

enough to constitute a violation of the Medical Practice Act. Although the board can prosecute cases against physicians for gross negligence or incompetence, the law does not allow the board to prosecute cases against physicians for single incidents of simple negligence.* This limitation to its statutory authority is significant because most of the 1,285 cases closed with merit in 1981 involved simple negligence.

An example will illustrate the seriousness of the problems in cases of simple negligence. A physician performed surgery involving gastric stapling, a procedure which reduces the capacity of an obese person's stomach. After the operation, the patient developed a fever and had infrequent bowel activity. Seven days after the operation, the patient went into cardiorespiratory arrest and died. An autopsy revealed a perforation in the patient's stomach that permitted the food she consumed to spill into the abdominal cavity. As a result, the patient developed peritonitis, an infection of the lining of the abdominal cavity. This infection went undetected because the physician failed to perform tests that were indicated by the patient's post-operative condition. An outside medical expert, who evaluated the case, said that if

* Gross negligence is an "extreme departure from the standard of practice of medicine," and incompetence is a "lack of knowledge or ability in discharging professional medical obligations."

the physician had conducted the appropriate tests, the physician could have diagnosed the perforation in the patient's stomach. The outside medical expert further stated that operating at that time would have given the patient an excellent chance of survival. The medical expert concluded that the post-operative care the physician rendered was negligent and constituted a departure from the standard of care; this was not a case of gross negligence, however. Because the case involved simple negligence, it was closed with merit, and no action was taken against the physician.

In addition to limitations on the types of violations the board can prosecute, we also found that the board is limited in its access to patient records while investigating cases. The board is authorized to seize only those records that it can identify by patient name. Obtaining records by patient name precludes access to other records, which may evidence negligent medical care. This limited access to records may prevent the board from establishing a case against a physician for "repeated similar negligent acts," a type of violation in which the physician renders similar negligent medical care in more than one case.

Other agencies that investigate physicians' medical practices have greater access to records than the board has. Their access to records enables these agencies to develop a

broader evidentiary base. Unlike the board, which is required to investigate complaints about physicians' medical practices, these agencies have been mandated by the federal government to monitor the quality and necessity of care provided to Medi-Cal and Medicare patients. For example, the Department of Health Services' staff are authorized to examine all of a physician's Medi-Cal patient records to investigate allegations of fraud and abuse.

Also, Professional Standards Review Organizations (PSROs), nonprofit entities under contract to the federal government, review medical care provided to Medi-Cal and Medicare patients to determine if it is medically necessary and consistent with professionally recognized health care standards. PSROs can deny payment for procedures deemed unnecessary. Further, PSROs can apply sanctions to physicians who overuse medical services or provide substandard medical care. PSROs receive referrals on utilization and on quality of care issues from their review coordinators in hospitals. If a PSRO receives more than one referral for a physician, PSRO staff can pull a random sample of that physician's records on Medicare or Medicaid patients in all hospitals within the PSRO area in which the physician practices.

Lastly, the board is limited in its actions because it cannot require physicians to take competency examinations. The Oregon and Arizona medical boards are empowered to compel physicians to submit to competency examinations during any part of an investigation. However, California's board can only take action against physicians while exercising its disciplinary authority. Thus, without an imposed disciplinary action against a physician, California's board has no authority to require that physician to take a competency examination. If the medical boards in Oregon and Arizona identify deficiencies, they can take appropriate action, such as restricting the physician's medical practice or requiring additional education or training, without going through the whole administrative hearing process.

CONCLUSION

The Board of Medical Quality Assurance could improve its enforcement procedures in interviewing physicians, making arrests, and requiring psychiatric examinations. The board could also further its efforts to use a nondisciplinary approach when dealing with physicians who inappropriately prescribe drugs.

The board is acting appropriately in opening cases, using special operators, examining patient records, complying with the opinions of outside medical experts, and serving accusations on physicians.

Finally, the board is limited by statute in its authority to act against all licensees who have demonstrated deficiencies in medical competency.

RECOMMENDATION

The Board of Medical Quality Assurance could improve its enforcement procedures by doing the following:

- Interviewing all physicians charged with noncriminal violations after investigative evidence has been obtained and before serving the physician with a formal accusation;

- Evaluating whether to employ alternatives to physical arrest, such as voluntary surrender and issuing misdemeanor citations, in cases where risk factors are minimal;

- Informing physicians of their right to submit evidence in their behalf before they are required to have a psychiatric examination; and

- Placing a high priority on educating physicians in appropriate drug prescribing practices.

The board should also recommend to the Legislature ways of dealing more effectively with physicians who demonstrate simple negligence in their medical practice. Such a proposal should consider protecting the rights of physicians, furthering public protection, and continuing to operate within existing budgetary resources.

II

THE DIVERSION PROGRAM FOR IMPAIRED PHYSICIANS NEEDS IMPROVEMENT

Our review of the Diversion Program for Impaired Physicians disclosed two deficiencies. First, compliance officers are not adequately monitoring and enforcing treatment programs. Second, participants diverted from the enforcement program who do not comply with their treatment programs are not being terminated from the program and referred back to the enforcement program for possible disciplinary action. These deficiencies result from a lack of established policies and procedures for monitoring compliance with treatment programs and from a lack of standards for terminating participants. Because of these deficiencies, there is no assurance that the public is being adequately protected during the process of rehabilitating physicians who suffer from drug or alcohol abuse or from physical or mental illness. However, during the course of our review, the board began to correct each of these problems.

Program History

In 1979 the Legislature enacted the Diversion Program for Impaired Physicians, which was designed to identify and rehabilitate physicians who suffer from drug or alcohol abuse

or from physical or mental illness. The program is the first of its kind in the country for rehabilitating physicians. Its objective is to protect the public safety and welfare while rehabilitating physicians whose skills may be impaired.

The Diversion Program, which began operation in January 1980, is voluntary and accepts physicians who refer themselves. Physicians about whom the board has received complaints may also enter the program if the board's investigations disclose that these physicians are suffering from alcohol or drug abuse or from physical or mental illness. If a physician under investigation is referred to the program, the investigation is halted once the physician enters the program. However, should the physician quit the program before successfully completing it, the investigation is reinstituted. When a participant successfully completes the treatment program, all the participant's records are destroyed, and the participant may return to the practice of medicine with full privileges.

Before a physician is accepted as a participant in the Diversion Program, the physician is screened by the program manager and by one of five Diversion Evaluation Committees. The program manager and the committee meet with the physician to determine the physician's eligibility and extent of impairment. Once the physician is accepted into the program,

the committee develops an individual treatment program, consisting of various terms and conditions with which the physician must comply.

The program currently serves 109 active participants: 74 participants, 68 percent, were referred by the Enforcement Program; the remaining 35 are self-referrals. The Diversion Program's budget for fiscal year 1981-82 is approximately $347,000. These funds come primarily from licensing fees paid by physicians and surgeons.

Deficiencies in Monitoring and Enforcing Treatment Programs

The Business and Professions Code, Section 2352(f), requires that the Diversion Evaluation Committee establish a treatment program for each physician participating in the Diversion Program. The physician, in signing the treatment program, agrees to cooperate with all its elements, including supervision and surveillance by the program's compliance officers. These officers are supposed to monitor the participants' activities to ensure that they are complying with all the provisions of their treatment programs.

The board has not established policies governing frequency of contact with participants. As a result, we identified problems with monitoring and enforcement activities. First, the frequency of the compliance officers' contacts with the physicians varies. Our review of the case files of the 74 physicians diverted to the program by the Enforcement Program disclosed an average of 49 days between compliance officer contacts with physicians. However, frequency of contact varies widely. Some physicians have not been contacted at all, while others have not been contacted inasmuch as seven and one-half months. Two of the participants have not been contacted because one resides in another country and one resides in another state.

Furthermore, the frequency of contact appears to be decreasing. There was an average of 99 days between the date of the compliance officers' last visit with diversion participants and the date of our review, April 30, 1982. The time between these two dates ranges from as little as one day to almost one year. According to the program manager, this decrease in the frequency of contact occurred as a result of vacancies in compliance officer positions. However, all the vacant positions have now been filled, and the board plans to hire one more compliance officer in August 1982.

The second problem is that not all of the terms and conditions of the treatment plans are monitored and enforced. Each of the 74 treatment plans in our sample contained between 11 and 32 specific terms and conditions to be met by the physician. We examined 490 of the more significant terms and conditions and found that 105, or 21 percent, of these terms and conditions were not adequately enforced. For example, a compliance officer has not ensured that one of the five participants required to surrender their Drug Enforcement Administration permits has done so. These permits, issued by the federal government, allow physicians to write prescriptions for controlled substances. If a compliance officer fails to ensure that the physician surrenders the permit, the physician who has an identified drug abuse problem still has a means of obtaining drugs.

Another problem in monitoring treatment plans is that compliance officers do not always verify participants' attendance at group meetings. The group meetings, similar to the support group meetings of Alcoholics Anonymous or Narcotics Anonymous, are run by facilitators, and participants are usually required by their treatment programs to attend two meetings a week. Sixty-five of the participants in the program are required to attend Diversion Program group meetings or Alcoholics Anonymous or Narcotics Anonymous group meetings. However, we found that compliance officers were not verifying

the attendance of 10 of the participants, 15 percent. Attending these meetings is important because facilitators can continually monitor both the participants' rehabilitation progress and their abstinence from alcohol or drugs. Facilitators can immediately report any slips by participants to a compliance officer or the program manager.

Additionally, the compliance officers have not ensured that all participants' psychiatric reports are received. Forty-five of the participants were required to have their psychiatrists regularly submit reports on the participants' progress. In 13 of the 45 cases, 29 percent, these reports were not being submitted. These reports inform the program manager of the participant's progress, and they are particularly important for those participants who suffer from mental and emotional illness. Additionally, these reports provide information on the participant's condition and ability to practice medicine safely.

Furthermore, the program is not ensuring that physicians practice in a supervised, structured environment, a provision of a treatment plan that prohibits the physician from practicing alone. According to this provision, the physician must work in an environment that permits his or her practice to be overseen by another physician. The purpose of this restriction is to reduce the opportunity for the physician to

repeat incompetent acts or to return to alcohol or drug abuse. We found that 4 of the 27 participants required to work in supervised, structured environments were not doing so. According to guidelines recently developed by the board, the diversion participant is responsible for locating a supervised, structured environment and must submit a plan to the Diversion Program Manager for approval. However, these supervised, structured environments were not being approved by a Diversion Evaluation Committee or program manager in 13 of the 20 cases, 65 percent, where approval was required.* Additionally, supervisors were not submitting required reports on the physicians' performance in 17 of the 18 cases, 94 percent.

To determine the type of supervision a participant received while participating in the Diversion Program, we examined a specific case in which reports were not being received from a supervisor. The participant was employed full-time at one hospital and part-time at another. Since only one supervisor's name was indicated in the file, we contacted the compliance officer to obtain the name of the participant's other supervisor. The compliance officer could not provide the name of the other supervisor because the compliance officer did not know that the participant was employed part-time at the

* Before these recently drafted guidelines, approval was not required in all cases.

second hospital, even though the participant had been practicing there unsupervised for almost 17 months. After we informed him of this fact, the compliance officer indicated that he would obtain a supervisor at the second hospital for the physician.

These problems occurred because the board had not established policies for approving and monitoring supervised, structured environments for Diversion Program participants. This policy is needed because when physicians who are required to work in supervised, structured environments do not comply with that provision of their treatment plan, there is no assurance that the public is being adequately protected. In such cases, a physician could resume or continue abusing alcohol or drugs while on duty treating patients, and no other physicians may be available either to detect the physician's intoxification or to treat the physician's patients if the physician were to become incapable of treating them.

Finally, inadequate recordkeeping contributed to the deficiencies we noted in the board's monitoring and enforcement of treatment plans. Records on each participant are scattered among three separate files: one maintained by the program manager, one by the compliance officer, and one in the central file. We reviewed the records in the central file because they constitute the formal record of the participants' progress.

Using these files, we were unable to determine whether compliance officers were monitoring 93, 19 percent, of the 490 terms and conditions in the treatment plans we reviewed. We could not conclude, however, whether this problem reflected lack of monitoring or simply lack of complete recordkeeping.

Deficiencies in Terminating Participants from the Program

According to the California Administrative Code, participants may be terminated from the Diversion Program for a variety of reasons. For instance, participants can be terminated if they fail to comply with the treatment programs designed by the Diversion Evaluation Committees, if they have not substantially benefited from the program, or if their continued participation creates too great a risk to the public's health, safety, or welfare.

In our review of participants in the Diversion Program, we identified six participants who had not been referred back to the enforcement program for possible disciplinary action even though they were not meeting a significant number of terms and conditions of their treatment programs. These terms and conditions included abstaining from alcohol and drug use; working in a supervised, structured environment; attending group meetings; abiding by all state,

federal, and local laws and rules governing the practice of medicine; and surrendering the Drug Enforcement Administration permit to prescribe controlled substances.

In one case, for example, the participant was allowed to remain in the program despite repeated instances of noncompliance. The case involved a physician who entered the Diversion Program for addiction to heroin. Part of the terms and conditions of his treatment program included abstaining from the use of all controlled substances, taking naltrexone twice a week, not substituting for physicians on vacation, and obeying all state, federal, and local laws and rules governing the practice of medicine.*

Our review of this case disclosed four separate instances of noncompliance with the participant's treatment program, none of which resulted in terminating the participant from the program. First, the compliance officer reported on six separate occasions that the physician was not taking his naltrexone as required. Second, cocaine was detected in a urine specimen taken from the participant on a day he was treating patients. The participant also admitted to using cocaine on another occasion. Third, the participant was

* Naltrexone is a drug taken to block the effects of opiates, including heroin and demerol but not cocaine.

arrested for driving under the influence of drugs. And finally, the compliance officer reported that, contrary to an amendment to his treatment plan, the physician was still substituting for physicians on vacation. In a four-week period, the participant had substituted three times for other physicians.

The compliance officer consistently reported these instances of noncompliance. Furthermore, a Diversion Evaluation Committee member wrote to the program manager stating that this participant's behavior was intolerable and that it endangered the program. The committee member recommended terminating the participant, but that recommendation was not acted upon.

These deficiencies result from a lack of established standards and guidelines for terminating participants. In particular, the board has not clarified the requirement that a physician be terminated from the program when that physician is deemed too great a risk to public health, safety, or welfare, especially when the physician is either under the influence of alcohol or drugs or mentally or physically disabled while caring for patients.

Corrective Action Taken

During our review, the board initiated action to correct the deficiencies that we have identified. To improve the overall efficiency of the program, the board plans to hire a deputy program manager responsible for supervising compliance officers. This change is effective in fiscal year 1982-83 upon approval of the position by the State Personnel Board. The board has also drafted formal guidelines for supervised, structured environments imposed on physicians in the Diversion Program. These guidelines, which include establishing the specific steps for approving participants' supervised environments, require the participant to submit a plan of employment to the compliance officer and the program manager. The compliance officer then inspects the environment, interviews the prospective supervisor, and submits recommendations to the program manager.

Additionally, the board has drafted standards for terminating participants from the Diversion Program. These standards include terminating physicians who are under the influence of alcohol or drugs while caring for patients, who are in noncompliance with their treatment programs, or who are mentally or physically disabled while caring for patients. The

board has requested comments from the Diversion Evaluation Committees on what would constitute noncompliance. The board will consider these comments in defining the standards.

Although the board has not established formal policy in other areas, it has given high priority to developing a policy for the frequency of contacts between compliance officers and participants, for developing a more structured job description and performance measures for compliance officers, and for consolidating the filing system.

CONCLUSION

Our review disclosed deficiencies in monitoring and enforcing treatment programs and in terminating those participants from the Diversion Program who do not comply with their treatment programs.

However, during our review, we found that the Board of Medical Quality Assurance is aware of these problems and is taking appropriate action to correct them.

RECOMMENDATION

To ensure that the Board of Medical Quality Assurance complies with its proposal to correct the deficiencies in the Diversion Program, the board should provide a schedule for establishing the frequency of compliance officer contact with program participants and for developing a more structured job description and performance measures for compliance officers.

INFORMATION REQUESTED BY THE LEGISLATURE

Physicians Required to Work in Supervised, Structured Environments Employed in State Hospitals

The terms and conditions of probation or the provisions in the treatment plan for the Diversion Program may require a physician's practice to be limited to a supervised, structured environment.* The purpose of requiring a physician to work in a supervised, structured environment is to assure public safety. Physicians generally require structure and supervision when competency problems, substance abuse problems, or emotional problems dictate the need for close scrutiny and frequent observation of their medical practice. These physicians are prohibited from practicing alone.

The physician is responsible for locating employment in a supervised, structured environment and for submitting a plan to the board's regional medical consultant or Diversion Program Manager for approval. The supervisor is provided with

* Placing a physician on probation is one disciplinary action that the board may take.

the terms and conditions of the physician's restricted practice and is fully aware of the physician's problems. The supervisor is responsible for monitoring the physician.

We reviewed the case files of those physicians on probation and those in the Diversion Program whose practices are restricted and who are employed at state hospitals. In addition, we contacted hospital administrators to verify the extent of the supervision and to determine what the physicians' hospital duties entail. From our review, we found 10 physicians on probation and 1 physician in the Diversion Program working in state hospitals. Details about each of these physicians are contained in Table 2, which follows.

TABLE 2

PHYSICIANS WITH RESTRICTIONS
ON THEIR PRACTICE WHO ARE EMPLOYED IN STATE HOSPITALS

Probationer/ Diversion Participant	Medical Specialty	Violation	Hospital Supervision	Relationship Between Violation and Supervised Environment	Relationship Between Medical Specialty and Duties at Hospital
State Hospital A					
Probationer 1	Obstetrics, Gynecology	Gross negligence, incompetence	- Direct supervision by a physician on daily basis - General observation by hospital colleagues - Hospital peer review	Supervision necessary to ensure prohibition of obstetrical deliveries	Condition of probation precludes practice in medical specialty Hospital duties consist of performing physicals and preparing medical histories for psychiatric patients
State Hospital B					
Probationer 1	Family Practice	Alcohol Abuse	- Supervision by program director - General observation by hospital colleagues - On-going peer review - Supervision by physician in charge during night shifts	Supervision is necessary to ensure Probationer 1 abstains from drugs and alcohol A supervised, structured environment was not a condition of probation, but Probationer 2 voluntarily found employment at the state hospital	Both physicians provide primary medical care
Probationer 2	Family Practice	Addiction to drugs and alcohol			
State Hospital C					
Probationer 1	Internal Medicine and General Practice	Use of controlled substances (narcotics and restricted dangerous drugs)	- Minimal hospital supervision - Program manager sees physician daily - Hospital colleagues provide general observation	Supervision is necessary to ensure abstinence from controlled substances	General practitioner at hospital

TABLE 2 (Continued)

Probationer/ Diversion Participant	Medical Specialty	Violation	Hospital Supervision	Relationship Between Violation and Supervised Environment	Relationship Between Medical Specialty and Duties at Hospital
State Hospital D					
Probationer 1	General Practice	Narcotics Addiction	- Supervision by program director and medical supervisor	Supervision is necessary to ensure abstinence from controlled substances	Both physicians provide primary medical care
Probationer 2	General Practice	Violation of narcotics regulations	- Ongoing hospital drug audits - General observation by hospital staff - Supervision by Nursing Officer of the Day on night shifts		
State Hospital E					
Probationer 1	Otolaryngology (ears, nose, and throat)	Mental illness, negligence, and use of narcotics	- Supervision by program director and program nurse - Performance review by credentials staff - Performance review by Nursing Officer of the Day on night shifts	Supervision is necessary to ensure abstinence from controlled substances and to enforce restrictions on drug prescribing practices	Primary care of developmentally disabled patients
Probationer 2	Anesthesiology and Primary Care	Drug Abuse			
State Hospital F					
Probationer 1	Psychiatry	Drug prescribing violations	- Direct supervision by the medical officer daily - Occasional meetings with the program director - Hospital peer review	Supervision is necessary to ensure prohibition of prescribing controlled substances	General psychiatric treatment which does not require prescribing drugs

TABLE 2 (Continued)

Probationer/ Diversion Participant	Medical Specialty	Violation	Hospital Supervision	Relationship Between Violation and Supervised Environment	Relationship Between Medical Specialty and Duties at Hospital
State Hospital G					
Probationer 1	Psychiatry	Sex with female patients	General supervision by the chief of the department	Supervision necessary to prohibit treatment of female patients; hospital is an all-male facility	Psychiatric care to patients
State Hospital H					
Diversion Participant 1*	Anesthesiology	Use of drugs	Informal supervision; supervisor assists in problems upon request from the physician	Restriction of prescribing practices to hospital	General practice; respiratory therapy; dental anesthesia; tracheostomy

* Involves part-time employment at the state hospital.

Our review of physicians on probation who are required to work in supervised, structured environments employed in state hospitals showed that the supervision appears to be adequate. Generally, probationers are assigned medical supervisors and administrative supervisors and are observed by colleagues and by peer review committees. Working at night does not preclude observation because supervisors generally report on the physicians' performance. Lastly, although matching the physician's specialty with hospital responsibilities is not always possible because of the terms of the probation, most physicians are assigned duties similar to those of their previous practice.

Supervision for the physician in the Diversion Program working in the state hospital is informal. The supervisor assists in problems upon request from the physician. This supervision appears to be adequate, however.

Denial of Licenses to Practice Medicine

Applicants for a physician's and surgeon's license are required to complete specific questions on their applications regarding previous criminal convictions and disciplinary actions. The applicants must also submit their fingerprint cards with the applications. The Division of Licensing verifies the answers about prior criminal convictions

by submitting applicants' fingerprints to the Department of Justice. It does not, however, independently verify answers to questions about prior disciplinary actions in other states. Applications having no evidence of convictions and no indication of previous disciplinary action are processed for licensing.

Applications indicating criminal convictions or disciplinary actions receive additional review. If the applicant has minor convictions, such as traffic violations or participation in college demonstrations in the 1960s, the Program Manager of the Division of Licensing will approve the application. All other applications indicating more serious convictions or disciplinary actions are reviewed by a subcommittee. This subcommittee, which consists of the board's chief medical consultant, the Program Manager of the Division of Licensing, and the President of the Division of Licensing, reviews the applicant's criminal convictions or disciplinary actions. The subcommittee frequently requests that the applicant have an administrative psychiatric evaluation to determine the applicant's ability to practice medicine. Based on the recommendations of the psychiatrist, the subcommittee decides whether to approve or to reject the application. Applicants who are denied licenses may request an administrative hearing.

We reviewed the eight applications since 1976 that were denied because of disciplinary actions or criminal convictions. One applicant was initially denied a license because he had been convicted of fighting in a public place. Further review revealed that the applicant had successfully completed his probation, and he was granted a license. The remaining seven applicants were denied licenses because of disciplinary actions in other states, such as narcotic addiction, writing prescriptions without conducting an examination, psychiatric illness, illegally dispensing controlled drugs, incompetency, and failure to appear in court for numerous traffic violations. One of these applicants, disciplined in another state for taking dangerous drugs, was eventually licensed after agreeing to participate in the board's Diversion Program for Impaired Physicians.

Respectfully submitted,

THOMAS W. HAYES
Auditor General

Date: August 11, 1982

Staff: Robert E. Christophel, Audit Manager
Ann Arneill
Cora L. Bryant
Sandra L. Lee

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825

August 5, 1982

Thomas W. Hayes
Auditor General
Office of the Auditor General
660 J Street, Suite 300
Sacramento, California 95814

Dear Mr. Hayes:

We have reviewed your report on the Board of Medical Quality Assurance and are pleased to comment on its findings. The detailed study conducted by your staff has resulted in suggestions which will enable us to improve our effectiveness, and we appreciate the constructive and supportive tone of the document.

It is especially gratifying that although you have directly addressed a variety of complaints about alleged improprieties, abuse of authority, and non-responsiveness in our enforcement activities, these have been largely not substantiated. Thus we may focus our attention on those issues which deserve consideration.

The Board is continually frustrated by deficiencies in the current law limiting our ability "to act against all licensees who have demonstrated deficiencies in medical competence". We hope that enough attention can be directed to this area by the Legislature and others to secure meaningful reforms. The suggestions in the report to increase our authority to address "simple" negligence and to gain access to needed medical records will be pursued enthusiastically by the Board.

The criticism of the Impaired Physicians Program is justified and, as the report states, we have already moved to correct the deficiencies. We feel that the steps which have been taken in policy development, staffing, and management systems will satisfactorily resolve these problems in the near future.

Finally, we would like to express our appreciation for the professional and sensitive conduct of your staff during this

study and report. While being under such close scrutiny for many months cannot be described as pleasant, the auditors involved made every effort to minimize their impact on daily activities and were consistently both gracious and thoughtful.

Sincerely,

ROBERT ROWLAND
Executive Director

RR/bh

OTHER STATE AND FEDERAL AGENCIES THAT INVESTIGATE PHYSICIANS' ACTIVITIES

We received complaints from physicians about improprieties they felt the board had committed in its investigations. We found that one of these complaints did not involve the board but rather involved another state agency that investigates physicians' activities. Because the actions of other state agencies were not within the scope of the audit, we did not review the propriety of those actions. However, in this section, we discuss the responsibilities of other governmental agencies that conduct investigations of physicians.

The Drug Enforcement Administration of the United States Department of Justice is responsible for enforcing federal laws dealing with controlled substances and preparing for prosecution cases against anyone involved in the manufacture or distribution of controlled substances appearing in or destined for illicit drug traffic. The Drug Enforcement Administration also works independently or sometimes in conjunction with the board in investigating physicians suspected of diverting controlled substances to illicit markets.

The Bureau of Quality Control within the Federal Department of Health and Human Services is responsible for investigating complaints of fraud and abuse by physicians providing medical services through Medicare and by beneficiaries of that program. This division and the board keep each other informed about active investigations of physicians.

The California Department of Health Services' Investigations Branch is responsible for investigating complaints of fraud and abuse by physicians providing medical services through the Medi-Cal program and by beneficiaries of that program. The board and the Investigations Branch keep each other informed of active investigations, but they do not conduct investigations jointly. The agencies will usually file joint accusations against physicians at the close of their separate investigations.

The California Department of Health Services' Surveillance and Utilization Review Branch is responsible for performing postpayment reviews of computerized utilization data for physicians providing Medi-Cal services and for Medi-Cal beneficiaries. The purpose of these reviews is to identify fraud, abuse, and overutilization of Medi-Cal services. The Surveillance and Utilization Review Branch reviews Medi-Cal records at physicians' offices and at hospitals to determine

whether the services were reasonably necessary for the patient's health care, whether the services were of acceptable quality, and whether the charges were appropriate. The Surveillance and Utilization Review Branch and the board keep each other informed of active investigations and frequently file joint accusations against physicians.

The California Department of Justice's Medi-Cal Fraud Unit is responsible for investigating, auditing, and prosecuting all types of Medi-Cal fraud involving criminal charges against providers of medical and pharmaceutical services. The unit and the board keep each other informed of active investigations, and in some instances they investigate cases together.

The California Department of Justice's Bureau of Narcotic Enforcement is responsible for investigating the activities of narcotic dealers, clandestine drug manufacturers, and dispensing violators in the medical and pharmaceutical professions. The Bureau of Narcotic Enforcement and the board keep each other informed of active investigations, and they also conduct investigations jointly.

SOURCES OF COMPLAINTS AGAINST PERSONS WHO MAY BE IN VIOLATION OF THE MEDICAL PRACTICE ACT

The Board of Medical Quality Assurance has statutory authority to investigate complaints against physicians and surgeons. The board has the authority to initiate an investigation whenever a charge or complaint has been brought against a licensee. However, such charges or complaints can be submitted by a variety of sources. Allegations against a licensee may be submitted by any consumer, individual, or group.

Most complaints are received from the physician's patient or from a person representing the patient. Other common sources of complaints include other licensees and other government agencies, such as the United States Department of Justice's Drug Enforcement Administration, the California Department of Health Services, or local law enforcement offices.

There are also reporting requirements for entities that provide licensees with liability insurance, for the licensee himself if he or she has no liability insurance, for court clerks, and for health facilities. These entities are

required by law to provide information to the board on charges against any licensee; these entities are thus additional sources of complaints against licensees.

Section 801 of the Business and Professions Code requires that all insurers providing professional liability insurance to physicians or surgeons submit reports to the board. The reports are required to include any settlement awards over $30,000 for damage claims for death or personal injury caused by the licensee's negligent or unauthorized practice. These reports are to be submitted to the board within 30 days of the settlement agreement.

Section 802 of the Business and Professions Code requires physicians and surgeons without liability insurance to submit reports of settlements against their practice to the board. The information required in these reports is similar to that required under Section 801 of the Business and Professions Code.

Section 803 of the Business and Professions Code requires that a court clerk report any licensee who has committed a crime or who is liable for any death or personal injury caused by negligent or unauthorized action.

Finally, Section 805 of the Business and Professions Code requires health facilities to report to the board any licensee who has been denied staff privileges, who has been suspended from the facility, or who has had staff privileges limited.

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
State Controller
Legislative Analyst
Director of Finance
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps